5/pt. 4

Department of
Veterans Affairs

Geriatrics and Extended Care

Domiciliary Care

M–5, Part IV
December 6, 1990

Veterans Health and
Research Administration
Washington DC 20420

VA 1.18:

READEX FICHE best copy available

Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC 20420

1. Transmitted is a revision of Veterans Health Services and Research Administration Manual M-5, "Geriatrics and Extended Care," Part IV, "Domiciliary Care."

2. The revision delineates current mission and operating requirements.

3. **Filing Instructions**

Remove	**Insert**
Cover through iii	Cover through iii
1-1 through 7-1	1-1 through 6-1
	A-1 through A-4

3. **RESCISSIONS**: M-5, Part IV, dated August 30, 1985, and VHS&RA Circular 10-87-130.

JAMES W. HOLSINGER, JR., M.D.
Chief Medical Director

Distribution: **RPC: 1146**
FD

Printing Date: 12/90

M-5, Part IV

Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC 20420

December 6, 1990

The Department of Veterans Affairs, Veterans Health Services and Research Administration Manual M-5, "Geriatrics and Extended Care," Part IV, "Domiciliary Care Program," is published for the compliance of all concerned.

JAMES W. HOLSINGER, JR., M.D.
Chief Medical Director

Distribution: **RPC: 1146**
FD

Printing Date: 12/90

FOREWORD

The Domiciliary Care Program represents a distinct component of VA (Department of Veterans Affairs) comprehensive continuum of health care services. Two distinct types of care are offered in the Domiciliary; short-term active biopsychosocial rehabilitation and long-term health maintenance care. This program is also a clinically appropriate level of care for the homeless veteran whose clinical care needs are not severe enough to require more intensive levels of treatment.

In a therapeutic homelike environment, the Domiciliary Care Program provides active residential rehabilitation directed toward development of the skills necessary for return to community-based living. Clinical interventions are intended to provide optimal opportunity for community interaction, vocational involvement and graduated independence not available at other levels of care. The Domiciliary Care Program's clinical interventions build on the strengths of the veteran, enhance quality of life experiences and maximize potential for independent functioning.

CONTENTS

CHAPTER 1. INTRODUCTION

PARAGRAPH PAGE

1.01 Definition 1-1

1.02 Types of Domiciliary Care 1-1

CHAPTER 1. INTRODUCTION

1.01 DEFINITION

a. **Domiciliary care is authorized by 38 CFR 17.47, 17.48, 17.49.** The provisions of each citation must be fully addressed in determining eligibility for domiciliary care.

b. **Domiciliary Care Program.** A residential rehabilitation program that provides short-term rehabilitative and long-term health maintenance care for veterans who require minimal medical care. The domiciliary care program also provides health care and related services to eligible homeless veterans. Domiciliary patients are normally ambulatory and do not require the level of clinical intervention or observation routinely provided to nursing home patients. It provides a full range of rehabilitation services for patients who do not require bedside nursing care. It provides a semi-structured, therapeutic environment, while providing optimal opportunities for community interaction both inside and outside the institution.

c. **Minimal Medical Care.** The level of care which offers a degree of clinical intervention and therapeutic structure that is greater than community residential care but less than nursing home or hospital based psychiatric care. VA domiciliary care has often been described as the least intensive level of VA inpatient care.

d. **Rehabilitation.** Physical, psychosocial, vocational, and behavioral interventions or activities required to bring the patient to optimal levels of functional independence and health while seeking to provide an optimal quality of life. (See app. A.)

1.02 TYPES OF DOMICILIARY CARE

a. **Biopsychosocial Rehabilitation.** Those clinical interventions and services required to effect, to the extent possible, remediation of medical, psychosocial and vocational impairments essential to the restoration of the patient to an optimal level of functional independence and health.

b. **Long-term Health Maintenance Care.** Those clinical interventions and services required to prevent or delay, to the extent possible, those degradations in functional status and/or health that would, if unchecked, be expected to result from the progression of chronic disease.

CONTENTS

CHAPTER 2. RESPONSIBILITIES

PARAGRAPH PAGE

2.01 Chief, Domiciliary Care Program 2-1

2.02 Domiciliary Advisory Board 2-1

2.03 Interdisciplinary Treatment Teams 2-1

2.04 Domiciliary Screening Committee 2-2

2.05 Domiciliary Patient's Advisory Council 2-2

CHAPTER 2. RESPONSIBILITIES

2.01 CHIEF, DOMICILIARY CARE PROGRAM

a. The Chief, Domiciliary Care Program, a bed service chief reporting to the Chief of Staff, is responsible for all aspects of a comprehensive program of care for domiciled veterans and for the efficient, effective operation of the domiciliary care program

(1) All staff assigned to the domiciliary, both clinical and administrative, will be programmatically accountable to the Chief, Domiciliary Care Program, while remaining professionally and organizationally accountable to their respective service chiefs.

(2) Chief, Domiciliary Care Program, will directly supervise the domiciliary staff responsible for provision of 24 hours coverage of the domiciliary.

2.02 DOMICILIARY ADVISORY BOARD

a. A DAB (Domiciliary Advisory Board) is an interdisciplinary board, composed of chiefs of services involved in the provision of domiciliary care. The DAB will advise on matters of interdisciplinary planning, evaluation of treatment modalities and programs. The DAB reports to the Clinical Executive Board of the medical center.

b. The medical center or domiciliary (White City) director will designate the membership of the DAB and assign membership to it from each of the professional services designated to provide support services to the domiciliary. The Chairperson of the DAB will be the Chief, Domiciliary Care Program.

c. The Chief, Domiciliary Care Program, is responsible for the full implementation of therapeutic initiatives and programs. The Chief, Domiciliary Care Program, will report to the DAB on the effectiveness of treatment initiatives and make recommendations when necessary.

d. A DSC (Domiciliary Screening Committee) will function as a sub-committee of the DAB. Domiciliary quality assurance activities will be conducted in a manner consistent with JCAHO (Joint Commission of Accredited Hospital Organizations) Accreditation Manual for Hospitals, appendix A, part II.

e. A Domiciliary Care Quality Management Committee will function as a subcommittee of the DAB.

2.03 INTERDISCIPLINARY TREATMENT TEAMS

a. Interdisciplinary treatment teams, designated by the Chief, Domiciliary Care Program, will be responsible for treatment planning and service delivery for domiciliary care patients. The teams will include representation from the services involved in the provision of direct care to domiciliary patients.

b. Each new admission will be interviewed by interdisciplinary team members to assess treatment needs and be scheduled to meet with the team to formulate treatment and discharge plans. This process will be implemented within 3 workdays after admission of the patient and completed within 2 weeks.

c. The organization of the team will vary depending on treatment objectives and patient load. The team normally includes physicians, social workers, nurses and allied health staff. Other consultative and support staff may include representatives from any of the health care professions (e.g., psychiatry, psychology, dietetics, pharmacy, dentistry, ophthalmology, podiatry, audiology and rehabilitation therapies).

d. The patient treatment plan/activity schedule will be coordinated/monitored by a treatment team member.

e. Interdisciplinary treatment teams will review patient treatment plans/activity schedules as frequently as needed, but in no case shall this review exceed an interval of 6 months. This review will assess current treatment, patient progress, need for continued care and discharge plans. The patient will be present at such formal reviews. The results of such review will be fully recorded in the patient's consolidated health record.

f. Each patient will be assigned a schedule of daily therapeutic activities. The activities will be related to the patient's abilities, interests and the therapeutic goals developed by the team in conjunction with the patient. The therapeutic reasons for the activities will be explained to the patient.

2.04 DOMICILIARY SCREENING COMMITTEE

A DSC (Domiciliary Screening Committee) will be established to review appropriateness of applications for domiciliary care. The DSC will be composed of an interdisciplinary staff fully acquainted with the Domiciliary Care Program. The DSC will determine the treatment needs of the applicant and select those patients most likely to benefit from domiciliary care.

2.05 DOMICILIARY PATIENT'S ADVISORY COUNCIL

a. A Patient's Advisory Council will serve as a forum for discussions by patients in the domiciliary, including operational and administrative issues, complaints and other matters of concern, and will serve in a advisory capacity to the Chief, Domiciliary Care Program.

b. Council By-laws, subject to approval by management, will provide for election of representatives by patients, selection of council officers, and term of office for officers and representatives.

c. The Chief, Domiciliary Care Program, will serve as liaison between veterans and staff.

CONTENTS

CHAPTER 3. PROGRAM MANAGEMENT

PARAGRAPH		PAGE
3.01	Admissions	3-1
3.02	Criteria for Admission	3-1
3.03	Patient Selection	3-2
3.04	Admitting Records	3-2
3.05	Absences	3-2
3.06	Transfer to Hospital	3-3
3.07	Inter-Domiciliary Transfer	3-3
3.08	Discharge	3-3
3.09	Procedure of Release	3-4
3.10	Medical Care Records	3-4

CHAPTER 3. PROGRAM MANAGEMENT

3.01 ADMISSIONS

a. Domiciliary care will be furnished within the limitations of VA facilities to those veterans eligible under the provisions of 38 CFR 17.47 and 17.48.

b. Procedures and responsibility for determining legal eligibility are contained in M-1, part I, chapter 4. All applicants must meet current income criteria unless a rebuttal statement is approved by the VA medical center or VA domiciliary Director. Justification for the granting of income limitation waivers will be documented in the consolidated health record.

c. Procedures and responsibility for determining clinical eligibility are contained in chapter 5.

d. The Chief, Domiciliary Care Program, is responsible for domiciliary bed control, and will coordinate admissions with the Chief, Medical Administration Service.

e. Immediately prior to completion of admission procedures, the Chief, Domiciliary Care Program, or designee, will explain the mission of the domiciliary program to the applicant and give the veteran a copy of the domiciliary care handbook containing necessary program information.

f. Veterans under involuntary commitment status will not be considered appropriate for admission to the domiciliary care program.

3.02 CRITERIA FOR ADMISSION

a. A VA physician will determine the medical need of the applicant in accordance with M-1, part I, chapter 4, and 38 CFR 17.47(c)(3) or (d)(3). To be found clinically eligible for admission to the VA Domiciliary Care Program, an applicant must present with impairment(s) of mind and/or body sufficient in degree to cause a qualified physician to determine that care in an institutional setting is essential to the effective provision of necessary health care services, that the applicant is and will remain for at least a period of time unable to pursue substantially gainful employment and is currently unable to provide adequately for self in the community. An additional requirement for domiciliary care is the ability of the veteran to:

(1) Accomplish activities of daily living with minimal assistance.

(2) Receive clinical care on an ambulatory basis or by use of self-managed wheelchair or other assistive devices.

(3) Actively participate in prescribed treatment, rehabilitation and/or health maintenance activities.

(4) Make rational and competent decisions to remain in or to leave the domiciliary.

(5) Share by personal effort, in some measure, as part of a therapeutic program, in the maintenance and operation of the health care facility. Patients assume responsibility for the housekeeping of life space in the living unit to which assigned.

(6) Maintain appropriate, self-directed behaviors and freedom from behaviors that would constitute a danger to self or others.

(7) Handle full privileges and authorized absences as deemed therapeutically appropriate.

(8) Be free of active substance abuse.

b. Legally blind veterans meeting all other admission criteria will be admitted if they have completed mobility training at a VA Blind Rehabilitation Center or equivalent program. If the veteran has not had such training, referral should be made to the nearest Blind Rehabilitation Center or Clinic for admission such training. Contact should be made with the Chief of the Blind Rehabilitation Program concerning referral of the veteran(s).

c. Patient applicants for admission must clearly demonstrate motivation for rehabilitation and/or health maintenance services.

3.03 PATIENT SELECTION

a. Clinical eligibility shall be determined by a physician who is fully acquainted with the domiciliary care program and the professional care provisions of this manual.

b. All applicants will be reviewed by the Domiciliary Screening Committee. After this review, a decision will be made regarding the status of the applicant's admission request. In determining each applicant's need for institutional care, specific consideration will be given to the use of available State Home Program resources as a clincially appropriate, cost effective alternative to VA domiciliary care.

c. Direct applicants will be seen by the admitting physician who will consult with the Chief, Domiciliary Care Program, in determining appropriateness of admission to domiciliary care.

d. Reasons for admission will be fully documented in the patient record.

e. When an applicant does not meet criteria for domiciliary care, assistance will be given by Social Work Service to assure that the veteran obtains necessary services through other VA, State or community resources.

3.04 ADMITTING RECORDS

a. Medical Administration Service will initiate and maintain the records which will be required during a patient's stay in the domiciliary. (See M-1, pt. I, ch. 5.)

b. VA Form 10-5510, Photo Identification for Domiciliary Patient, will be issued to each patient upon admission. The card will be kept on the patient's person at all times and will be shown for identification upon request by VA personnel. The card will be surrendered when the veteran departs on discharge or on authorized absence when the bed is not being reserved.

3.05 ABSENCES

a. Authorized patient absences will be administered in accordance with provisions of M-1, part I, chapter 10.

b. Patients are encouraged to make use of authorized absences for therapeutic purposes.

c. The authority for granting absences is the responsibility of the Chief, Domiciliary Care Program in collaboration with the patient's treatment team.

d. Authorized absence may be granted for periods up to 30 days. Extensions may be granted when therapeutically indicated. An absence shall not extend beyond the due date of the patient's annual physical examination.

e. Patients on authorized absence not exceeding 96 hours are considered bed occupants and their beds will be reserved. Patients granted absences in excess of 96 hours are considered absent bed occupants and will be dropped from the remaining count. (See M-1, pt. I, ch. 10.)

f. When a patient on authorized absence is admitted to a VA medical center for treatment, the absence will be cancelled and the status will change to ASIH (absent, sick in hospital).

g. Patients who fail to return from authorized absence may be placed in unauthorized absence status only if they are in receipt of an institutional award and discontinuance would cause financial hardship.

h. Patients who leave the domiciliary or medical center without approval may be placed in unauthorized absence status if they meet the provisions of subparagraph g., or if they are certified by their physician to be unable to understand the significance of their actions.

3.06 TRANSFER TO HOSPITAL

a. When a domiciliary patient's condition becomes such that domiciliary treatment programs and/or resources are insufficient to satisfy the treatment needs of the patient, the patient will be transferred without delay to a hospital or nursing home care bed section as appropriate.

b. Patients exhibiting dangerous or uncontrollable behavior will be transferred to an acute care setting for appropriate medical and/or psychiatric management and supervision.

3.07 INTER-DOMICILIARY TRANSFERS

The treatment team will recommend and the Chief, Domiciliary Care Program, will approve/disapprove actions relative to inter-domiciliary transfers. Transfers may be initiated when clinically determined and documented factors indicate that the therapeutic need of a patient cannot be met at the present domiciliary.

3.08 DISCHARGE

See M-1, part I, chapter 12.

a. **Regular discharge will be given to:**

(1) Patients whose health care status no longer requires domiciliary care, and who are determined by the treatment team to be able to provide adequately for themselves or otherwise be provided for in the community.

(2) Patients who request discharge while present or while in authorized absence status.

(3) Patients who remain in ASIH status after 30 days.

(4) Patients who are admitted to the Nursing Home Care Unit.

b. **Preparation for Regular Discharge**

(1) Discharge planning will be initiated during the admission/treatment planning process. The discharge plan will be clearly documented in the clinical record.

(2) A realistic discharge date will be established and communicated to each veteran at the time of admission.

(3) An appropriate discharge preparation program will be instituted to prepare the patient to function in the community.

(4) Discharge plans will be developed and implemented by treatment teams in cooperation with the patient, consistent with Domiciliary Care Program policies.

c. **Irregular discharge may be given to:**

(1) Patients who request discharge against medical advice,

(2) Patient who fail to return from authorized absence,

(3) Patients who leave the facility without approval, or

(4) Patients who refuse, neglect, or obstruct reasonable care and treatment. (See M-1, pt. I, ch. 1, par. 1.26a(2).)

d. **Preparation for Irregular Discharge**

When a veteran is to be discharged on an irregular basis, efforts will be made to assist in obtaining alternative services. Veterans requiring such assistance will be referred to Social Work Service.

3.09 PROCEDURE OF RELEASE

a. The Chief, Domiciliary Care Program, will establish clearance procedures for patients departing on discharge or on authorized absence.

b. The treating physician will prepare a summary of treatment prior to discharge of patient.

3.10 MEDICAL CARE RECORDS

In accordance with the provisions of M-1, part I, chapter 5, a consolidated health record will be maintained for each active patient. A consolidated health record will contain a record of all medical histories, physical examinations, laboratory reports, treatment plans, treatments, behavioral observations, progress notes, psychosocial information, hospitalization, medication, diet and consultations.

CONTENTS

CHAPTER 4. CLINICAL CARE

PARAGRAPH		PAGE
4.01	Treatment Plan Responsibility	4-1
4.02	Interdisciplinary Services	4-1
4.03	Service Delivery Process	4-1
4.04	Clinical Care Programs	4-2
4.05	Vocational Initiatives	4-3
4.06	Admission Evaluation	4-4
4.07	Medical Care	4-5
4.08	Infection Control	4-5
4.09	Medical Considerations for Discharges	4-6
4.10	Additional Professional Services	4-6
4.11	Research Initiatives	4-7

CHAPTER 4. CLINICAL CARE

4.01 TREATMENT PLAN RESPONSIBILITY

a. A qualified physician will be responsible for supervising the provision of medical services to individual patients and for meeting the general public health needs of the domiciliary community.

b. Coordination of professional services and evaluation procedures will be accomplished through the inter-disciplinary team. Individual patient care plans will be developed by the treatment teams. Care plans will include: reason for admission, treatment goals (short- and long-range) and an appropriate plan for discharge. Each patient will participate in the development of their treatment and discharge plan.

4.02 INTERDISCIPLINARY SERVICES

a. Treatment programs in the Domiciliary Care Program are comprehensive, structured, and individualized; they are the product of an interdisciplinary treatment planning process. The Domiciliary Care Program offers the following services to meet participants needs:

(1) **Medical services** include initial evaluation, prescription of treatment, medication review, ongoing clinical management and consultation with patient's key therapists.

(2) **Nursing services** include comprehensive health assessment; ongoing monitoring of the progress of participants; preventive health care; health counseling and education of patients, families, and other staff; and coordination of patient care.

(3) **Social Work Service** provides a comprehensive psychosocial assessment which will be used for treatment and discharge planning purposes. Emphasis is placed on the development of a plan that will promote the veteran's optimal use of the domiciliary experience and return to community living. The social worker functions as a casemanager, linking the patient with family or support system and the community health and social services network.

(4) **Psychological services** provide a comprehensive psychological and vocational assessment on all domiciliary patients.

(5) **Nutrition services** include nutritional counseling and education.

(6) **Therapeutic recreational activities** planned to meet the physical and social needs of the participants, are an integral part of the individual's treatment program.

(7) **Rehabilitation treatment services** provided on an individual and/or group basis by professional and paraprofessional personnel, include but are not limited to occupational therapy, speech therapy, physical therapy, kinesio-therapy, vocational rehabilitation services and compensated work therapy.

b. Domiciliary program staffing will be multi-dimensional, sometimes transcending traditional discipline oriented boundaries.

4.03 SERVICE DELIVERY PROCESS

(1) **Outreach.** Efforts will be made to reach the homeless and resource deficient veterans where they congregate. This includes emergency community shelters, street

corners, and soup kitchens. In addition, self-referral and hospital referral will be encouraged through effective information dissemination.

(2) **Admission Assessment and Treatment Plan Development.** The health status of the veteran will be evaluated and the clinical needs ascertained. Appropriate clinically-oriented treatment and discharge plans will be developed and implemented with the patient as an active participant. Treatment and discharge plans will be based upon information gained through comprehensive interdisciplinary patient assessment. This process will be initiated within 3 work days and be completed within 2 weeks.

(3) **On-going Assessment.** Frequent patient progress evaluation must be continuous and must be recorded to ensure continued appropriateness of planned clinical interventions and therapeutic goals and objectives.

(4) **Discharge Planning and Outplacement.** The discharge planning process begins with the initial assessment. Efforts must be made to ensure continuity in the provision of appropriate clinical services once the patient leaves the treatment program. In addition, adequate living arrangements must be made and potential employment possibilities explored. Outplacement possibilities include transfer from shorter term biopsychosocial rehabilitation to long-term health maintenance domiciliary care, return to independent living or referral to community-based care programs. Specific considerations of State Veterans Homes and Community Residential Care Programs as alternative placements are encouraged when continued structure is deemed most therapeutic for the veteran after receiving maximum therapeutic benefit from domiciliary care.

(5) **Aftercare and Monitoring.** Once the veteran has returned to the community, steps must be taken to ensure that plans for ongoing treatment through VA and non-VA programs will not be disrupted. It is expected that outreach and treatment team personnel will, as needed, develop strategies to monitor patients adjustment to community living after discharge from the homeless program. Aftercare/monitoring activities will be recorded in the patient's treatment file.

4.04 CLINICAL CARE PROGRAMS

a. Domiciliary care utilizes a broad range of clinical care services and programs to address the needs of veterans. This care is provided by:

(1) Domiciliary based programs specifically tailored to the needs of the domiciliary patient, and

(2) The full scope of hospital based programs and services provided to the domiciliary patient on an outpatient basis.

b. Domiciliary Care Programs typically include sobriety maintenance, vocational assessment and counseling, work restoration, head trauma rehabilitation, and AIDS/HIV disease support services and psychiatric rehabilitation services.

c. Domiciliaries may develop innovative domciliary-based programs designed to meet specialized needs of some patient population subgroups, i.e., lithotripsy patients, oncology patients, and patients requiring institutional support during periods of pre-hospitalization, evaluation and assessment as well as post-hospital treatment and rehabilitation.

d. **DCHV (Domiciliary Care for Homeless Veteran) Program**

(1) **General**

(a) In response to the increasing number of homeless veterans, the Domiciliary Care Program has developed the DCHV Program to address the complex needs of the homeless veteran. The DCHV provides:

1. Community outreach and referral,

2. Admission screening and assessment,

3. Medical and psychiatric treatment (including substance abuse treatment) and social-vocational rehabilitation, and

4. Post-discharge community support.

(b) The goal of the program is clinical, social and vocational rehabilitation directed toward the earliest possible return of functional independence and health for each veteran treated. This process, for as many veterans as possible, will facilitate independent or semi-independent reintegration into community-based living.

(2) **Program Highlights**

(a) Innovation, creativity and originality are encouraged in program development and implementation. Programmatic flexibility is encouraged to successfully address the unique needs of individual patients.

(b) Clinically appropriate services are provided primarily through the use of existing domiciliary and hospital based delivery systems. Case management by appropriate interdisciplinary treatment team members is initiated to ensure a comprehensive continuity of clinical care.

(c) Using the interdisciplinary treatment team and case manager model, each patient's treatment will be individualized.

(d) Care may include, but is not limited to, clinical interventions, patient education, basic living skills, vocational assessment/counseling, social skills, work restoration and community re-entry skills.

(3) **Therapeutic Community**

Necessary treatment can often best be provided in the therapeutic community milieu which has evolved in the domiciliary setting. Emphasis is placed on personal responsibility, improved self-esteem through accomplishment and a problem-solving attitude. An effective therapeutic community environment provides the springboard from which more specific treatments can be administered. It also provides patients opportunities to increase their overall sense of self-worth and self-confidence.

4.05 VOCATIONAL INITIATIVES

a. Vocational strengths and deficits will be identified by the interdisciplinary treatment team with referral to the most appropriate rehabilitative treatment providers.

b. Such rehabilitation may include, but is not limited to:

(1) Vocational assessment testing and counseling,

(2) Incentive therapy program,

(3) Compensation work therapy program,

(4) Live in/work out program, and

(5) Referral to community-based job resources.

c. Vocational assessment and rehabilitation will be directed toward restoration of vocational readiness to support return to independent or semi-independent community reintegration.

d. Return to full community living will be expected of patients participating in live-in/work-out activities as soon as they have acquired adequate resources for such transition. Treatment team will monitor and document patient's progress.

e. Patients participating in live-in/work-out programs will be required to maintain their own living area, account daily for their presence, and keep required medical appointments. They will be excused, as appropriate, from other scheduled domiciliary activities.

4.06 ADMISSION EVALUATION

a. An admission history and complete physical examination will be completed on each patient. Requests for special examinations, tests, and laboratory procedures will be initiated within 48 hours of admission. This examination will include:

(1) General physical examination and special examinations as may be indicated.

(2) An electrocardiogram will be done when clinically indicated.

(3) Blood serological tests for syphilis, complete blood count and appropriate blood chemistries and urinalysis.

(4) Oral examination by a dentist.

(5) Other examinations as may be indicated such as, but not limited to; hearing, glaucoma, podiatry, and physical tolerance testing.

b. When patients from a VA medical center are discharged to a VA domiciliary or returning from ASIH status, the domiciliary will be provided discharge summaries and other information needed to assure continuity of care.

c. For those patients whose disabilities are primarily psychosocial, the referring health care facility should forward a current summary including all relevant medical and psychosocial information to assist in the determination of suitability for admission. This information will be reviewed by the DSC.

4.07 MEDICAL CARE

There will be vigorous efforts to prevent the onset of preventable diseases and disabilities associated with infections and chronic diseases as well as the aging process through initiation of activities such as AIDS/HIV disease education and counseling, immunization, weight control, education against addictive habits, early cancer detection, glaucoma testing, hearing tests, exercise, leisure education, early detection and prompt treatment of clinical disorders.

a. **Annual Medical Examinations**

(1) Each patient will have an annual comprehensive medical and dental examination. The report of examination will include a statement of medical need for continuance of domiciliary care. A complete physical examination with necessary clinical laboratory tests will be a part of the comprehensive medical examination. If the patient has had such a medical examination in the interim since admission (such as during a period of hospitalization) the annual examination will be performed within 1 year of that last examination.

(2) Notification of determination of medical ineligibility for continued domiciliary care as a result of such a medical examination must be made to the Chief, Domiciliary Care Program, as early as possible and no later than 5 working days.

(3) Chest X-rays will be obtained in accordance with accepted medical practice.

(4) TB skin tests will be performed annually.

b. Chest X-ray will be obtained when clinically indicated. If indicated, a sputum examination for active tuberculosis also will be completed. An intercutaneous administration of 5 units of PPD (purified protein derivative) tuberculin (Mantoux text) should be administered. One week later, a second PPD should be done if the first one was negative to rule out a booster effect in subsequent positive tuberculin tests. Reference should be made to MMWR 5-18-90, Vol. 39, No. RR-8. A positive test can now be defined from 5mm of induration to 15mm induration depending on many variables.

4.08 INFECTION CONTROL

Each domiciliary care program will establish and maintain an infection control program in accordance with procedures outlined by the Committee on Hospital Infections. The Domiciliary Care Program will implement a comprehensive infection control prevention program to adequately address patient care needs.

a. **Immunization Program.** Each domiciliary will establish and maintain an active immunization program and followup system in accordance with accepted medical practice. All immunizations must be appropriately recorded in the patient's clinical record.

b. **Tuberculosis Control**

(1) The Chief of Staff is directly responsible for maintaining an effective tuberculosis control program for patients.

(2) All new admissions will be administered a two step PPD with at least two controlled skin tests placed within 1 week of admission. PPD testing will be administered annually in a one step procedure after initial testing.

(3) All new PPD's should be evaluated for active tuberculosis. All skin tests should be appropriately recorded in millimeters induration in the patient's clinical record.

(4) Domiciliary staff working with a patient population known to be at risk for tuberculosis should consider participation in a program of regular testing.

(5) Patients with a history of tuberculosis which was not adequately treated with chemotherapy must have a chest X-ray annually. Those who have not received adequate chemotherapy should be considered for therapy according to current American Thoracic Society recommendations. Persons with a history of tuberculosis who have received appropriate chemotherapy will be treated the same as the rest of the population regarding chest X-rays.

(6) When tuberculous is suspected, the patient will be immediately transferred to the medical center for further examination and treatment. Concurrently, patients and staff who are known to have been exposed will be examined for infection in accordance with M-2, Part IV, "Medical Service." Any symptoms suggestive of tuberculosis will receive prompt attention.

4.09 MEDICAL CONSIDERATIONS FOR DISCHARGES

a. Administrative provisions for discharge of patients is contained in M-1, part I, chapter 13, and M-1, part I, chapter 4, paragraph 4.22.

b. Prior to discharge of patient, the need for physical examination will be determined by the treating physician. If the physician recommends continued domiciliary care, the patient will be so advised and the physician's decision will be recorded in the health record. If the patient leaves against the physician's advice, the provisions for irregular discharge in M-1, part I, chapter 13, will apply.

c. Irregular discharges may be initiated by the Chief, Domiciliary Care Program, in consultation with the treatment team for patients who refuse to cooperate with medical rehabilitative programs and procedures, or for patients who persist in obtaining medical services and medication from non-VA sources. All such recommended discharges must be cleared by a physician as not endangering the patient's health.

4.10 ADDITIONAL PROFESSIONAL SERVICES

a. Services including but not limited to the following list will ensure that care is provided domiciliary patients in accordance with programs designed as appropriate and necessary for domiciliary care which has a primary emphasis on treatment, rehabilitation and return to community living. Programs will also be provided for patients who require supportive maintenance care in an institutional setting, but who do not require hospitalization or skilled nursing care.

(1) Audiology and Speech Pathology Service

(2) Blind Rehabilitation Service

(3) Building Management Service

(4) Chaplain Service

(5) Dental Service

(6) Dietetic Service

(7) Laboratory Service

(8) Library Service

(10) Nursing Service

(11) Optometry Service

(12) Pharmacy Service

(13) Podiatry Service

(14) Prosthetics Service

(15) Psychiatry Service

(16) Psychology Service

(17) Recreation Service

(18) Rehabilitation Medicine Service

(19) Social Work Service

(20) Voluntary Service

b. Sufficient qualified staff (as determined by centrally approved program standards and criteria) will be assigned to ensure appropriate access to treatment programs in the domiciliary necessary to provide quality care for patients.

4.11 RESEARCH INITIATIVES

a. Domiciliary care personnel are encouraged to submit innovative research proposals through their local R&D (Research and Development) offices. Additional information may be obtained by contacting Medical Research Service, VA Central Office (142A).

b. Research focused on aging has been designated by the R&D as a special emphasis area. In addition, aging research foci have been developed by each GRECC (Geriatric Research, Education and Clinical Center).

CONTENTS

CHAPTER 5. GENERAL ADMINISTRATIVE

PARAGRAPH PAGE

5.01 Employee and Patient Relations..... 5-1

5.02 Wills and other Legal Transaction for Patients..... 5-1

5.03 Building Management..... 5-1

5.04 Reporting..... 5-1

5.05 Additional Administrative Requirements..... 5-1

CHAPTER 5. GENERAL ADMINISTRATIVE

5.01 EMPLOYEE AND PATIENT RELATIONS

a. Employees will not accept gifts, compensation for services, or bequests from domiciliary care patients. Exception be requested under the provisions of 38 CFR 0.735.11 and 38 CFR 12.1.

b. Employees will not lend, borrow, or hold money or property, or engage in personal, financial transactions with domiciliary care patients.

c. Domiciliary care patients will not perform any personal service for employees.

5.02 WILLS AND OTHER LEGAL TRANSACTIONS FOR PATIENTS

See M-1, part I, paragraph 1.45.

5.03 BUILDING MANAGEMENT

Chief, Building Management Service, is responsible for implementation of policies and objectives defined in VA manuals M-1, part VII and M-00-2. In cooperation with the Chief, Domiciliary Care, the Building Management program will:

a. Provide safe, sanitary and homelike environment in the domiciliary.

b. Maintain all general areas of the domiciliary, not designated patients' personal living space (i.e., bedrooms).

c. Be responsible for establishment of cleaning requirements and provisions of training, equipment and direction for patients performing cleaning duties within the domiciliary care program.

5.04 REPORTING

Statistical reporting will be in accordance with MP-6, VI, supplement No. 1.2, chapter 21.

5.05 ADDITIONAL ADMINISTRATIVE REQUIREMENTS

The following provisions of M-1, part I, apply to domiciliary care patients in the same manner as for medical center patients:

a. Absences - chapter 10.

b. Admissions - chapter 4.

c. Bed Controls - chapter 1.

d. Beneficiary Travel - chapter 25.

e. Clothing, Incidentals and Service - chapter 4. (See also M-1, pt. VII, ch. 9.)

f. Medical Record - chapter 5.

g. Miscellaneous Operating Policies - chapter 1.

h. Personal Funds - chapter 8.

i. Personal Funds - chapter 1.

j. Releases From Inpatient Care - chapter 13.

k. Release of Information - chapter 9.

l. Report Changes in Status to Other VA Departments and Service Departments - chapter 6.

m. Transfers - chapter 11.

n. Deaths - chapter 14.

o. Seriously Ill - chapter 14.

CONTENTS

CHAPTER 6. DOMICILIARY CARE PROGRAM REPORTS

PARAGRAPH PAGE

6.01 Reports 6-1

6.02 Annual Narrative Report, RCS 10-0172 6-1

APPENDIX

A Quality of Life A-1

CHAPTER 6. DOMICILIARY CARE PROGRAM REPORTS

6.01 REPORTS

a. **AMIS Reports RCS 10-0021.** This report, submitted through the AMIS (Automated Management Information System), will be prepared and transmitted to Austin DPC in accordance with the procedures provided in VA Manual MP-6, part VI, supplement No. 1.2, chapter 21, section 2103.00, VA Nursing Home and VA Domiciliary Activity Code Sheet, VA Form 10-7400-2 (AMIS), Segments 345 and 346.

b. **RCS 10-0141.** The report should be reviewed and concurred in, by Chief, Domiciliary Care Program, prior to submission to ensure that the support from administrative, professional and support service accurately reflects the number of personnel assigned to the domiciliary.

c. **Annual Report of Domiciliary Care Program (Narrative Report)**

6.02 ANNUAL NARRATIVE REPORT, RCS 10-0172

a. **Purpose.** The Annual Narrative Report of the Domiciliary Care Program provides local management and VA Central Office with current basic information regarding major program elements having administrative, or clinical significance to the Domiciliary Care Program.

b. **Form of Report.** The Annual Narrative Report of the Domiciliary Care Program will be prepared by the Chief, Domiciliary Care Program, in coordination with professional services providing program and staff support to the domiciliary. The report will be prepared in triplicate on letter-size paper, dated and identified by the medical center's or domiciliary's name and the report control symbol. Information contained in the report will be concise and brief, not to exceed three typewritten pages, exclusive of attachments.

c. **Frequency and Report Period.** The report will be prepared annually at the close of the fiscal year.

d. **Distribution and Forwarding Date.** The Narrative Report is the report of the Chief Domiciliary Care Program. The original and one copy will be forwarded through the Assistant Director, Chief of Staff, and the medical center or domiciliary Director, each of whom may comment on any materials in the report by endorsement, to reach VA Central Office within 15 workdays after the close of the fiscal year. Reports will be addressed to the ACMD (Assistant Chief Medical Director) for Geriatrics and Extended Care (145A), through the Regional Director (13_/145A).

e. **Instructions for Content of Report.** Only significant developments or changes need be reported. Report will include a copy of the Table of Organization and Functional Chart in Domiciliary Care Program and a listing of professional staff assigned to the Domiciliary Care Program, and will focus on progress in the development of the domiciliary treatment programs. The report should be organized in relation to and include reference to areas as follows:

(1) **Therapeutic Rehabilitation Programs**

a. Medical

b. Psychological

c. Social

d. Educational/Vocational

e. Incentive therapy

(2) **Discharge planning and community outplacement.**

(3) **Quality assurance program activities.**

(4) **Quality of life/domiciliary living environment.**

(5) **Patient Advisory Council activities.**

(6) **Research**

(7) **Staff development/education and training.**

(8) **Patient health education program activities.**

(9) **Remarks.**

Include centrally or locally assigned tasks, projects, innovative program developments or problems not reportable under the headings.

QUALITY OF LIFE

1. GENERAL

a. Quality of life refers to the extent to which a patient is able to achieve security, self-esteem, and the opportunity to use intellectual and physical capabilities in pursuit of personal goals in the domiciliary.

b. This concept implies a life that is as meaningful and satisfying as qualities of mind and body permit.

c. Quality of life is not a static concept, but has variables which have changing values to each person during one's life cycle.

2. ASSESSMENT OF QUALITY OF LIFE FEATURES

In addressing the need to provide the highest possible quality of life for domiciliary care patients, it is essential that each domiciliary, to the extent that program resources allow, provide:

a. An Environment That Provides for Personal Space

(1) Appropriate room furnishings, such as chair, desk, lamps, dresser, and locker in a defined personal space.

(2) A place to park an appropriately licensed and insured automobile.

(3) Space to store large objects and belongings within the facility.

(4) Space and encouragement to display personal articles within the patient's living area.

(5) Freedom to arrange furniture within limitations of space and with management approval.

b. A Stable Environment With Predictable Aspects

(1) Formal orientation, including handbook.

(2) Stipulated time for meals and medications.

(3) Continuity of staff assigned to the domiciliary treatment teams and therapeutic programs.

(4) Stipulated appeal process related to proposed irregular discharge.

(5) Posted and circulated schedule of weekly activities.

(6) Scheduled activities program with emphasis of helping patients maintain as independent a lifestyle as possible, to include attention to personal grooming needs.

(7) Sufficient time for patients to pursue leisure time activities on their own.

(8) A staff person designated as patient's primary resource for counsel and assistance.

c. **An Environment That Encourages and Permits Choice**

(1) Some flexibility of sleep schedule.

(2) Freedom to leave domiciliary (with notification, when appropriate).

(3) Some choice in menu.

(4) Access to public transportation.

(5) Not be excluded from domiciliary for drinking alcoholic beverages unless resultant behavior is abusive or disturbing to others or unless consumption of alcohol represents a contravention of prescribed treatment or therapeutic community program ethic.

(6) Provisions for nonsmokers.

(7) A place to stay up late, if desired.

(8) Availability of laundry facilities, including washers and dryers, for patient's personal use.

d. **An Environment That Responds to Failing Faculties Without Fostering Dependence**

(1) Yearly vision, hearing and dental examinations.

(2) Availability of podiatry services.

(3) Enlarged print on signs and in reading material.

(4) Recognition of individual's need for special prosthetic/orthotic devices and established process of acquisition.

(5) Availability of barber or beautician for patients.

(6) Adequate lighting.

e. **Environment That allows recognition of individual interests through the Availability of Recreational, Educational, Vocational, and Spiritual Activities**

(1) Available current reading materials in domiciliary.

(2) Space for, and encouragement of hobbies.

(3) Opportunity to participate in recreational, productive work, educational, vocational, and spiritual activities on a regular basis, both in the domiciliary and in the community.

(4) Encouragement of physical exercise.

(5) Availability of regularly scheduled volunteers.

f. **An Environment That Encourages and Permits the Veteran to Maintain Contact with the Family, Family Surrogate, and the Community**

(1) A place to receive visitors in a private and pleasant environment without interference.

(2) Assistance in writing letters or making phone calls, including funding of calls, if necessary and as deemed appropriate.

(3) Encouragement to participate in community recreational and service activities.

(4) Use of personally owned television.

(5) Encouragement of family and friends to visit.

(6) Flexible visiting hours.

(7) Access to public telephone with visual, auditory, and physical adaptations.

g. **An Environment That Provides for Personal Security and Safety**

(1) Properly illuminated and posted walkways and crosswalks.

(2) Fire drill held in accordance with facility policy.

(3) A place to lock personal possessions.

(4) Slip-resistant surfaces in bathing facilities.

(5) Barrier-free environment.

(6) Communications system available at all times.

h. **A Climate That Enchances Human Dignity**

(1) VA Code of Patient Concern posted and given to staff and patients.

(2) Patient participation in formulation of rules, policies, and decision making through the Patient Advisory Council.

(3) Annual survey of patient satisfaction.

(4) Annual assessment of staff attitudes.

(5) Availability of human relations training for staff.

(6) Opportunity for patients to assist others.

(7) Residential environment.

(8) Empathic involvement of staff with patients.

(9) Privacy in toilets and in baths.

(10) Rights to information about disability.

(11) Patient Advisory Council with election of members and bylaws that outline rights and privileges of council.

★U.S. GOVERNMENT PRINTING OFFICE: 1991-282-80927413